STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY | DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

FOR STATE USE ONLY:
ADP BATCH NUMBER: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

FOR STATE USE ONLY:
DHS CUT OFF DATE: _____/_____/_____

Check one:
COUNTY CONTRACT. . . . [ ]
DIRECT CONTRACT. . . . . [ ]

DRUG MEDI-CAL
MONTHLY SUMMARY INVOICE

DATE _____

PAGE _____ OF _____

ITWS - 837P FILE NAME :

COUNTY	COUNTY CODE	REPORT MO/YR	CONTRACT NUMBER	PROGRAM CODE (check one)	FISCAL YEAR
		/		[ ] 20 (Alc/Drug 20-103) [ ] 25 (Perinatal 25-102)	

PROVIDER NAME	FACILITY / PROVIDER NPI	SDMC NUMBER	SFC	UNITS OF SERVICE	CLAIM AMOUNT PER PROVIDER / SFC DOLLARS / CENTS	ADJUSTMENTS TO CLAIMED AMOUNT				TOTAL REVENUE AND ADJUSTMENTS DOLLARS / CENTS	NET CLAIM DOLLARS / CENTS
						REVENUES		ADJUSTMENTS			
						SHARE OF COST (SOC)	OTHER	PSPP SITE VISIT	CLAIM ADJUST.		
			PAGE TOTALS		$				PAGE TOTALS	$	$
			GRAND TOTALS		$					Revenue/Adj. Total	Net Claim Total

PREPARER'S NAME (PLEASE PRINT CLEARLY) | PREPARATION DATE | PREPARER'S PHONE NUMBER ( ) | Grand Total of Invoice/Claim | $ | $

COUNTY CERTIFICATION

I CERTIFY the services listed on this form have been personally provided to the patient by the provider or under his direction by another person eligible under the Medi-Cal Program to provide such services and such person(s) are designated on this form. The services were, to the best of the provider's knowledge, medically indicated and necessary to the health of the patient. The provider understands that payment of this claim will be from Federal and/or State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and/or State laws. The provider agrees to keep for a minimum period of three years from the date of service all records which are necessary to disclose fully the extent of services furnished to the patient. The provider agrees to furnish these records and any information regarding payments claimed for providing the services, on request, to California Department of Health Care Services; Medi-Cal Fraud Unit, California Department of Justice; Medi-Cal Audits Project, Office of State Controller, U.S. Department of Health and Human Services, or their duly authorized representatives.

Medical care services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

SIGNATURE: X_____ **DATE:** _____ **EXECUTED AT:** _____**, CA**

COUNTY ALCOHOL/DRUG PROGRAM ADMINISTRATOR

DIRECT CONTRACT PROVIDER CERTIFICATION

I CERTIFY that I am the official responsible for the administration of Drug Program services in and for said claimant; that I have not violated any of the provisions of Sections 1090 through 1096 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Division 5 of the Welfare and Institutions Code; and that to the best of my knowledge and belief this claim is in all respects true, correct and in accordance with the law.

SIGNATURE: X_____ **DATE:** _____ **EXECUTED AT:** _____**, CA**

DIRECT CONTRACT PROVIDER ADMINISTRATOR

COUNTY or /DIRECT CONTRACT PROVIDER

I CERTIFY that I am the duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts.

SIGNATURE: X_____ **DATE:** _____ **EXECUTED AT:** _____**, CA**

TITLE:_____(EXAMPLE: COUNTY /DIRECT CONTRACT PROVIDER AUDITOR-CONTROLLER, FINANCE OFFICER, ETC.)

INSTRUCTIONS FOR SUBMITTING THE ADP 1592
(Revised February 2008)

I. GENERAL

The Drug Medi-Cal Monthly Summary Invoice, ADP 1592, is required by Alcohol and Drug Programs (ADP) to report Drug Medi-Cal (DMC) units of service, claim amounts, revenues and adjustments, and net claim amounts by county and direct contract providers having a contract with ADP. The information for all boxes/fields is required and must be complete and accurate for the claim to be processed.

II. HEADING INSTRUCTIONS

a. **Check one: COUNTY CONTRACT** or **DIRECT CONTRACT**
- **DIRECT CONTRACT** - check only for provider contracting with and submitting directly to ADP

b. **ITWS - 837P FILE NAME** - enter a single ITWS file name for claims summarized on this ADP 1592 Invoice.
- For county contracts: ADP_SDM_CO_P_837_YYYYMM_##, with or without the extension of zip or text.
- For direct contracts: ADP_SDM_PROV_P_837_YYYYMM_##, with or without the extension of zip or text.
- Claim summary information for each ITWS file should be summarized on a separate ADP 1592.

c. **COUNTY** - name of contracting county or name of direct provider's county

d. **COUNTY CODE** - enter the county's two digit code.

e. **REPORT MO/YR** - enter the month/year of the claim being submitted
- The latest Month and Year of the services in the claim file should be entered in this box.
- The ITWS file must only include claims, and the ADP 1592 Invoice must only summarize services for the same fiscal year.

f. **CONTRACT NUMBER** - enter the applicable Contract Number for either a County Contract or a Direct Contact based on the fiscal year's services.

g. **Program Code - (check one)** select the appropriate box for non-Perinatal DMC Program 20 or Perinatal DMC Program 25 services.
- A separate ADP 1592 Summary Invoice must be completed for each program code, and
- Each ADP 1592 must include the ITWS File Name, however
- Services for both programs may be submitted in a single ITWS File.

h. **Fiscal Year** - enter fiscal year for the services in the ITWS File named; only one Fiscal Year is allowed in an ITWS file and on an ADP 1592.

i. **Date** - enter the date this form is being completed and submitted, mailed/faxed, to ADP.

j. **Page __of __** - enter each page number and total number of pages for this ADP 1592; example of a 3-page submission: Page 1 of 3, Page 2 of 3, Page 3 of 3.

III. INSTRUCTIONS FOR ENTERING PROVIDER CLAIM INFORMATION

a. **PROVIDER NAME** - enter name of provider/program providing services.

b. **FACILITY/PROVIDER NPI** - enter the ten- (10-) digit National Provider Identifier (NPI).

c. **SDMC NUMBER** - enter four- (4-) digit SDMC Number assigned by ADP and formerly named the DMC Number

d. **SFC** - enter two- (2-) digit DMC service code:
- 20 for NTP Methadone Dose or 22 NTP Methadone Dose (SACPA)
- 26 NTP Individual Counseling or 27 NTP Individual Counseling (SACPA)
- 28 NTP Group Counseling or 29 NTP Group Counseling (SACPA)
- 30 Day Care Habilitative or 39 Day Care Habilitative (SACPA)
- 40 Perinatal Residential or 49 Perinatal Residential (SACPA)
- 50 Naltrexone or 59 Naltrexone (SACPA)
- 80 ODF Individual Counseling or 84 ODF Individual Counseling (SACPA)
- 85 ODF Group Counseling or 89 ODF Group Counseling (SACPA)

e. **UNITS OF SERVICE** - enter units per provider/SFC; per SFC listing rollup/summarize units under one SFC

f. **AMOUNT CLAIMED** - enter amount per provider/SFC; per SFC listing rollup/summarize amounts under one SFC

g. **ADJUSTMENTS TO CLAIMED AMOUNT** - enter applicable amounts in REVENUES or ADJUSTMENTS column(s)
- Enter any revenues collected and/or any adjustments reported for each provider/SFC
- Revenues and Adjustments must apply to the current fiscal year on the ADP 1592; no prior year adjustments should be included.
- Any non-SHARE OF COST (SOC) revenues should be listed under OTHER
- **PSPP SITE VISIT** - adjustments based on Post-Service/Post-Payment monitoring of claims
- List any other adjustments under **CLAIM ADJUST** column.

h. **TOTAL REVENUE AND ADJUSTMENTS** - enter total of the four (4) REVENUES and ADJUSTMENTS columns.

i. **NET CLAIM** - enter the CLAIM AMOUNT minus TOTAL REVENUE AND ADJUSTMENTS.

j. **PAGE TOTALS** - enter column totals for units of service, amount claimed, total revenue and/or adjustments and net claim.

k. **GRAND TOTALS** - on the last page of the monthly invoice, enter the grand totals of amount claimed, total revenue and/or adjustments and net claim.

IV. PREPARER'S NAME - the legible name and phone number (including the area code) of the responsible county/contractor representative for contact purpose.

V. CERTIFICATION STATEMENTS - sign the appropriate certification statement.

a. **COUNTY CERTIFICATION** - for a county contract only, enter the signature of the County Alcohol/Drug Program Administrator.

b. **DIRECT CONTRACT PROVIDER** - for a direct contract provider only, enter the signature of the Contract Administrator.

VI. FISCAL OFFICER - for contracting county or contracting direct provider

a. Enter the signature of the County Auditor Controller or Finance Officer for county; also enter the date and location where signed.

b. Enter the signature of the Direct Contractor Finance Officer for direct provider; also enter the date and location where signed.

c. Two (2) original signatures are required on the ADP 1592, the administrator and the financial officer.

d. Signatures are required on any page(s) that have the grand total(s) entered.

VII. Submission of ADP 1592 - ADP 1592 with original signatures and dates may either be faxed to **916-322-1176**, or mailed to:

Department of Alcohol and Drug Programs
Fiscal Management and Accountability Branch
1700 "K" Street, 4th Floor
Sacramento, CA 95811-4037

VIII. If there are adjustments to claims, please mail/fax the completed Adjustments by Provider, ADP 5035C with original signatures with the ADP 1592.